MICHIGAN CIVILIAN CONSERVATION CORPS ACT (EXCERPT)
Act 22 of 1984

409.308 Worker's disability compensation insurance.

Sec. 8. The department shall provide worker's disability compensation insurance for corpsmembers employed by the department, and recipients shall provide worker's disability compensation insurance for corpsmembers whom they employ as provided under the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

History: 1984, Act 22, Imd. Eff. Mar. 7, 1984.

WORKER'S DISABILITY COMPENSATION ACT OF 1969 (EXCERPT)
Act 317 of 1969

418.315 Furnishing medical care for injury arising out of and in course of employment; optometric service; attendant or nursing care; selection of physician by employee; objection; order; other services and appliances; proration of attorney fees; fees and other charges subject to rules; advisory committee; excessive fees or unjustified treatment, hospitalization, or visits; review of records and medical bills; utilization review; effect of accepting payment; submitting false or misleading information as misdemeanor; penalty; improper overutilization or inappropriate health care or health services; appeal; criteria or standards; certification; unusual health care or service.

Sec. 315. (1) The employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of this state as legal, when they are needed. However, an employer is not required to reimburse or cause to be reimbursed charges for an optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992. An employer is not required to reimburse or cause to be reimbursed charges for services performed by a profession that was not licensed or registered by the laws of this state on or before January 1, 1998, but that becomes licensed, registered, or otherwise recognized by the laws of this state after January 1, 1998. Attendant or nursing care shall not be ordered in excess of 56 hours per week if the care is to be provided by the employee's spouse, brother, sister, child, parent, or any combination of these persons. After 10 days from the inception of medical care as provided in this section, the employee may treat with a physician of his or her own choice by giving to the employer the name of the physician and his or her intention to treat with the physician. The employer or the employer's carrier may file a petition objecting to the named physician selected by the employee and setting forth reasons for the objection. If the employer or carrier can show cause why the employee should not continue treatment with the named physician of the employee's choice, after notice to all parties and a prompt hearing by a worker's compensation magistrate, the worker's compensation magistrate may order that the employee discontinue treatment with the named physician or pay for the treatment received from the physician from the date the order is mailed. The employer shall also supply to the injured employee dental service, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably possible, and relieve from the effects of the injury. If the employer fails, neglects, or refuses so to do, the employee shall be reimbursed for the reasonable expense paid by the employee, or payment may be made in behalf of the employee to persons to whom the unpaid expenses may be owing, by order of the worker's compensation magistrate. The worker's compensation magistrate may prorate attorney fees at the contingent fee rate paid by the employee.

(2) Except as otherwise provided in subsection (1), all fees and other charges for any treatment or attendance, service, devices, apparatus, or medicine under subsection (1), are subject to rules promulgated by the bureau of worker's compensation pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. The rules promulgated shall establish schedules of maximum charges for the treatment or attendance, service, devices, apparatus, or medicine, which schedule shall be annually revised. A health facility or health care provider shall be paid either its usual and customary charge for the treatment or attendance, service, devices, apparatus, or medicine, or the maximum charge established under the rules, whichever is less.

(3) The director of the bureau shall provide for an advisory committee to aid and assist in establishing the schedules of maximum charges under subsection (2) for charges or fees that are payable under this section. The advisory committee shall be appointed by and serve at the pleasure of the director.

(4) If a carrier determines that a health facility or health care provider has made any excessive charges or required unjustified treatment, hospitalization, or visits, the health facility or health care provider shall not receive payment under this chapter from the carrier for the excessive fees or unjustified treatment, hospitalization, or visits, and is liable to return to the carrier the fees or charges already collected. The bureau may review the records and medical bills of a health facility or health care provider determined by a carrier to not be in compliance with the schedule of charges or to be requiring unjustified treatment, hospitalization, or office visits.

(5) As used in this section, "utilization review" means the initial evaluation by a carrier of the appropriateness in terms of both the level and the quality of health care and health services provided an injured employee, based on medically accepted standards. A utilization review shall be accomplished by a carrier pursuant to a system established by the bureau that identifies the utilization of health care and health services above the usual range of utilization for the health care and health services based on medically accepted standards and provides for acquiring necessary records, medical bills, and other information concerning the health care or health services.

(6) By accepting payment under this chapter, a health facility or health care provider shall be considered to have consented to submitting necessary records and other information concerning health care or health services provided for utilization review pursuant to this section. The health facilities and health care providers shall be considered to have agreed to comply with any decision of the bureau pursuant to subsection (7). A health facility or health care provider that submits false or misleading records or other information to a carrier or the bureau is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00, or by imprisonment for not more than 1 year, or both.

(7) If it is determined by a carrier that a health facility or health care provider improperly overutilized or otherwise rendered or ordered inappropriate health care or health services, or that the cost of the health care or health services was inappropriate, the health facility or health care provider may appeal to the bureau regarding that determination pursuant to procedures provided for under the system of utilization review.

(8) The criteria or standards established for the utilization review shall be established by rules promulgated by the bureau. A carrier that complies with the criteria or standards as determined by the bureau shall be certified by the department.

(9) If a health facility or health care provider provides health care or a health service that is not usually associated with, is longer in duration in time than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the carrier to explain the necessity or indication for the reasons why in writing.

History: 1969, Act 317, Eff. Dec. 31, 1969;—Am. 1975, Act 93, Imd. Eff. May 27, 1975;—Am. 1981, Act 195, Eff. Mar. 31, 1982;—Am. 1985, Act 103, Imd. Eff. July 30, 1985;—Am. 1994, Act 271, Imd. Eff. July 11, 1994;—Am. 1995, Act 21, Imd. Eff. Apr. 12, 1995;—Am. 1998, Act 447, Imd. Eff. Dec. 30, 1998.

Compiler's note: For legislative intent as to severability, see Compiler's note to § 418.213.

For transfer of health care-related cost containment functions from the Bureau of Worker's Disability Compensation, Department of Labor, to the Office of Health and Medical Affairs, Department of Management and Budget, see E.R.O. No. 1982-2, compiled at § 18.24 of the Michigan Compiled Laws.

For transfer of duty to conduct hearings pursuant to § 418.315(7) to the Bureau of Workers' Disability Compensation, Department of Labor, see E.R.O. No. 1986-3, compiled at § 418.1 of the Michigan Compiled Laws.

For transfer of workers' compensation administrative rules functions to the Bureau of Workers' Disability Compensation, Department of Labor, see E.R.O. No. 1990-1, compiled at § 418.2 of the Michigan Compiled Laws.

Transfer of powers: See §§ 418.315 and 418.991.

Popular name: Act 317

Popular name: Heart and Lung Act

Administrative rules: R 418.10101 et seq. and R 418.10104 et seq. of the Michigan Administrative Code.

WORKER'S DISABILITY COMPENSATION ACT OF 1969 (EXCERPT)
Act 317 of 1969

418.351 Total incapacity for work; amount and duration of compensation; limitation on conclusive presumption of total and permanent disability; determining question of permanent and total disability.

Sec. 351. (1) While the incapacity for work resulting from a personal injury is total, the employer shall pay, or cause to be paid as provided in this section, to the injured employee, a weekly compensation of 80% of the employee's after-tax average weekly wage, but not more than the maximum weekly rate of compensation, as determined under section 355. Compensation shall be paid for the duration of the disability. The conclusive presumption of total and permanent disability shall not extend beyond 800 weeks from the

date of injury and thereafter the question of permanent and total disability shall be determined in accordance with the fact, as the fact may be at that time.

(2) A totally and permanently disabled employee whose date of injury preceded July 1, 1968, is entitled to the compensation under this act that was payable to the employee immediately before the effective date of this subsection, or compensation equal to 50% of the state average weekly wage as last determined under section 355, whichever is greater.

(3) If an employee who is eligible for weekly benefits under this act would have received greater weekly benefits under the prior benefit standard of 2/3 of average weekly wages, subject to the maximum benefits which were in effect before January 1, 1982, then the employee shall be entitled to such greater weekly benefits, but not at a rate exceeding the maximum rate in his or her dependency classification under such law. This subsection does not authorize payment to an employee according to any schedule of minimum benefits, except those provided in section 356.

History: 1969, Act 317, Eff. Dec. 31, 1969;—Am. 1976, Act 393, Imd. Eff. Jan. 3, 1977;—Am. 1980, Act 357, Eff. Jan. 1, 1982.

Popular name: Act 317

Popular name: Heart and Lung Act

WORKER'S DISABILITY COMPENSATION ACT OF 1969 (EXCERPT)
Act 317 of 1969

418.352 Supplement to weekly compensation.

Sec. 352. (1) Beginning January 1, 1982, an employee receiving or entitled to receive benefits equal to the maximum payable to that employee under section 351 or the dependent of a deceased employee receiving or entitled to receive benefits under section 321 whose benefits are based on a date of personal injury between September 1, 1965, and December 31, 1979, shall be entitled to a supplement to weekly compensation. The supplement shall be computed using the total annual percentage change in the state average weekly wage, rounded to the nearest 1/10 of 1%, as determined under section 355. The supplement shall be computed as a percentage of the weekly compensation rate which the employee or the dependent of a deceased employee is receiving or is entitled to receive on January 1, 1982 had the employee been receiving benefits at that time, rounded to the nearest dollar. The supplement shall not exceed 5% compounded for each calendar year in the adjustment period. The percentage change for purposes of the adjustment shall be computed from the base year through December 31, 1981. A supplement shall not be paid retroactively for any period of disability before January 1, 1982.

(2) For personal injuries occurring from September 1, 1965, through December 31, 1968, the base year shall be 1968. For personal injuries occurring between January 1, 1969 and December 31, 1979, the base year shall be the year in which the personal injury occurred.

(3) Pursuant to subsection (1), the director shall announce on December 1, 1981, the supplement percentages payable on January 1, 1982.

(4) All personal injuries found compensable under this act after the effective date of this section with a personal injury date before January 1, 1980, shall be paid at a rate determined pursuant to this section.

(5) An employee who is eligible to receive differential benefits from the second injury fund shall be paid the supplement pursuant to this section as reduced by the amount of the differential payments being made to the employee by the second injury fund at the time of the payment of the supplement pursuant to this section.

(6) The supplement paid pursuant to this section, when added to the original benefit, shall not exceed the maximum weekly rate of compensation provided in section 355 in effect on the date of the adjustment.

(7) An employee is not entitled to supplements under this section for a personal injury for which the liability has been redeemed.

(8) The supplements under this section shall be paid by an insurer or self-insurer on a weekly basis. The insurer, self-insurer, the second injury fund, and the self-insurers' security fund are entitled to quarterly reimbursement for these payments from the compensation supplement fund in section 391, except that an insurer or self-insurer subject to either section 440a of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.440a of the Michigan Compiled Laws, or section 38b of the single business tax act, Act No. 228 of the Public Acts of 1975, being section 208.38b of the Michigan Compiled Laws, shall take a credit under either section 440a of Act No. 218 of the Public Acts of 1956, or section 38b of Act No. 228 of the Public Acts of 1975, as applicable.

(9) This section does not apply to an employee receiving benefits under section 361(1).

(10) An insurer, self-insurer, the second injury fund, or the self-insurers' security fund shall make the supplemental payments required by this section for each quarter of the state's fiscal year that the state treasurer certifies that there are sufficient funds available to meet the obligations of the fund created in section

391 for that quarter. The state treasurer shall certify whether there are sufficient funds in the fund created in section 391 to meet the obligations of that fund for each quarter of the fiscal year of the state on or before the first day of each quarter.

(11) An insurer, self-insurer, the second injury fund, or the self-insurers' security fund shall make the supplemental payments required by this section for the period July 1, 1982 to September 30, 1982 and shall be reimbursed for those payments.

History: Add. 1980, Act 357, Eff. Jan. 1, 1982;—Am. 1982, Act 32, Imd. Eff. Mar. 10, 1982;—Am. 1982, Act 282, Imd. Eff. Oct. 7, 1982;—Am. 1984, Act 46, Imd. Eff. Apr. 9, 1984.

Popular name: Act 317

Popular name: Heart and Lung Act

WORKER'S DISABILITY COMPENSATION ACT OF 1969 (EXCERPT)
Act 317 of 1969

418.385 Physical examination of employee; payment; report; copy; evidence; failure of party to provide medical report.

Sec. 385. After the employee has given notice of injury and from time to time thereafter during the continuance of his or her disability, if so requested by the employer or the carrier, he or she shall submit himself or herself to an examination by a physician or surgeon authorized to practice medicine under the laws of the state, furnished and paid for by the employer or the carrier. If an examination relative to the injury is made, the employee or his or her attorney shall be furnished, within 15 days of a request, a complete and correct copy of the report of every such physical examination relative to the injury performed by the physician making the examination on behalf of the employer or the carrier. The employee shall have the right to have a physician provided and paid for by himself or herself present at the examination. If he or she refuses to submit himself or herself for the examination, or in any way obstructs the same, his or her right to compensation shall be suspended and his or her compensation during the period of suspension may be forfeited. Any physician who makes or is present at any such examination may be required to testify under oath as to the results thereof. If the employee has had other physical examinations relative to the injury but not at the request of the employer or the carrier, he or she shall furnish to the employer or the carrier a complete and correct copy of the report of each such physical examination, if so requested, within 15 days of the request. If a party fails to provide a medical report regarding an examination or medical treatment, that party shall be precluded from taking the medical testimony of that physician only. The opposing party may, however, elect to take the deposition of that physician.

History: 1969, Act 317, Eff. Dec. 31, 1969;—Am. 1985, Act 103, Imd. Eff. July 30, 1985.

Compiler's note: For legislative intent as to severability, see Compiler's note to § 418.213.

Popular name: Act 317

Popular name: Heart and Lung Act